



The Office of Vermont Health Access

**Medicaid Generic Reimbursement Reductions and
Dispensing Fee Study**

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Prepared with

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Acronyms, Definitions, and Identifications

AMP	The average prices for which manufacturers sell their products to purchasers. AMP represents the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies.
APC	Advanced Pharmacy Concepts: Data subcontractor to UCSOP.
AWP	The average wholesale price as the manufacturer has reported it and made it available for use. AWP represents a suggested retail price to pharmacies that is determined through a survey of pharmaceutical wholesalers. The AWP as used in this analysis is as listed by Medi-Span corresponding to the NDC code submitted by the pharmacist for the drug product on the date of service when the prescription claim was processed by the pharmacy.
Brand	A drug designated as a single source or multisource brand product (N, M or O designation) in the Medi-Span database.
CCPA Claims	Coalition for Community Pharmacy Action The requests from pharmacies for payment for individual drugs for individual beneficiaries. These claims are submitted to insurers including OVHA acting as the insurer for Vermont's publicly funded pharmacy programs.
CMS CMS FUL	Centers for Medicare and Medicaid Services CMS federal upper limit: CMS established ceiling for cost reimbursement for generic drugs. The federal upper limit is the maximum allowable cost paid by a federal program for a drug that is manufactured and/or distributed by multiple manufacturers.
Discount	The calculated Vermont program discount applied to the AWP price of the drug, resulting in the discounted ingredient cost.
DRA	Deficit Reduction Act of 2005
FDB	First Databank, Inc.: Drug data and pricing supplier.
FUL	Federal upper limit: See CMS FUL.
Generic	A drug designated as a generic product (Y designation) in the Medi-Span database. In this context generic refers to a drug's status as a generic product.
IC	The ingredient cost to the Vermont programs. This is the amount paid by OVHA for the drug product, prior to dispensing fee and any copay.
MAC	Maximum allowable cost: See OVHA MAC.
Medi-Span	Drug data and pricing supplier.
MedMetrics	MedMetrics Health Partners: OVHA's PBA.

NACDS	National Association of Chain Drug Stores
NCPA	National Community Pharmacists Association
NCPDP	National Council for Prescription Drug Programs, Inc.
NDC	National drug code: A NDC is assigned to each drug and consists of three segments. The first segment identifies the manufacturer; the second segment is the product code which identifies the drug's strength, dosage form, and formulation; and the third segment identifies the package size and type.
OVHA	Office of Vermont Health Access
OVHA MAC	The maximum allowable cost paid for a drug that is manufactured and/or distributed by multiple manufacturers, as established by OVHA's PBA.
PBA	Pharmacy benefit administrator: OVHA's PBA is MedMetrics Health Partners (MedMetrics).
PBM	Pharmacy benefit manager
PDP	Medicare Pharmacy Drug Plan
Submitted Cost	The payment amount requested by the pharmacy. Claims that request a payment of less than the OVHA pricing methodology are paid at the submitted amount.
U&C	The report of usual and customary price as reported on an individual claim by the pharmacy. U&C includes both product costs and dispensing.
UCSOP	University of Connecticut School of Pharmacy
V.S.A.	Vermont Statutes Annotated
WAC	Wholesale acquisition cost

Executive Summary

Section 107a of Act 215 of the Vermont General Assembly of the 2005-2006 Legislative Session (H.881) authorized a Medicaid generic reimbursement reduction and dispensing fee study.

While the focus of the text of this section is the anticipated reduction in Medicaid reimbursement for generic drugs under the federal Deficit Reduction Act of 2005 (H.R. 4241/S.1932) (DRA), the heading includes the study of dispensing fees.

Pharmacy business is both cost of dispensing and cost of products. The study here called for only the review of the cost of generic products affected by the DRA. To assure a thorough analysis, OVHA opted to include in the study all possible aspects of drug reimbursement in Vermont's publicly funded pharmacy programs. To assist in the study, the Office of Vermont Health Access (OVHA) contracted with the University of Connecticut School of Pharmacy (UCSOP).

The specific results related to Section 107a of Act 215 are:

1. The full potential impact of the DRA cannot be determined until federal rules proposed in December 2006 are finalized during 2007.
2. The average reported cost of dispensing individual prescriptions in pharmacies serving Vermont Medicaid is \$10.55.

Regarding Vermont programs' drug reimbursement the results are:

1. Vermont's current dispensing fee for in-state pharmacies is the highest dispensing fee of any New England Medicaid program for any pharmacy. That fee is also higher than the dispensing fees of New York Medicaid.
2. The price currently paid for brand drugs by OVHA programs is Average Wholesale Price reduced by 11.9% (AWP minus 11.9%). That is a higher price than paid by pharmacy benefit managers (PBMs) and commercial insurers in the Northeast where discounts against AWP are as much as 15.4%.
3. The Vermont Medicaid AWP reimbursement on brands is higher than the rates used by the other New England states and by the state of New York.
4. The Maximum Allowable Cost (MAC) discount/reimbursement structure for generics used by OVHA often pays less than the CMS Federal Upper Limit (FUL) generic reimbursement method commonly used by Medicaid programs in the region.
5. The OVHA MAC reduces payments more frequently than the current federal CMS FUL generic reimbursement model. With payments on generics based on the lesser of OVHA MAC, CMS FUL, usual and customary (U&C) charge, or AWP minus 11.9%, the frequency of use in this report's claims sample was OVHA MAC 66.3%, CMS FUL 15.7%, U&C 12.1%, and AWP pricing 5.9%. Thus the OVHA MAC is more

commonly less than the CMS FUL and, when it is, it results in lower payments on generics than the CMS FUL.

6. The DRA proposes to set the CMS FUL at 250% of the AMP. At that level, Vermont overall program costs would be less for generics assuming that the AMP rates available in July and August of 2006 are representative of the AMP rates as they will be used in calculating the CMS FUL.
7. While the use of AMP pricing logic for brand name medications is not called for under the DRA, at 250% of AMP the Vermont program reimbursement would increase on brands.
8. Wholesale Acquisition Costs (WAC) is considered a measure close to actual cost. OVHA currently pays more than WAC on brands but less than WAC on some generics.

In summary, Vermont publicly funded programs are paying:

- less than reported cost in the reimbursement for dispensing,
- more for dispensing than other Medicaid programs in New England and in the state of New York,
- more for brands than PBMs and other insurers in the Northeast region and Medicaid programs in other New England states and in New York state,
- more than WAC, a measure considered close to actual cost, on brands but less than WAC on some generics, and
- generally less than the generic reimbursement used by Medicaid programs in the region.

While at the moment Vermont programs may be paying less than the cost of dispensing, it appears that product reimbursement is greater than product cost in the most costly area of brands. Current generic reimbursement under the OVHA MAC while low compared to other regional Medicaid programs is more likely as a result to be closer to the DRA CMS FUL when calculated based on AMP at 250%. That means that generic reimbursement changes in Vermont programs as a result of the DRA may not be as dramatic as they may be in other states.

While things may change in the near future, there are many unknowns. Significant will be the evolving and final definitions and instructions under the DRA. Also significant will be potential national changes in the definition and use of other pricing options.

It is clear that changes are and will be occurring as early as calendar year 2007. However, at this juncture, it is impossible to completely identify them, much less assess the total impact on reimbursement for pharmacies or beneficiaries of Vermont's publicly funded programs. On a practical level, it would be unwise to consider changing reimbursement for dispensing costs as one aspect of the business, without knowing the effect of changes to the reimbursement for the products being dispensed.

Project Background and Overview

The Deficit Reduction Act (DRA) proposes an important pharmacy related change to one of the common benchmarks used to calculate certain drug cost reimbursements to pharmacies. Historically, this benchmark, Average Manufacturer Price (AMP), has not been used for Medicaid reimbursement. In 2007, AMP will be used by the Centers for Medicaid and Medicare Services (CMS) in establishing the Federal Upper Limit on select generics.

The critical issue is that this change will have an impact on Medicaid generic drug reimbursement logic on a national basis. The current logic uses manufacturers' published prices to establish a ceiling or Federal Upper Limit (FUL) for cost reimbursement for generic drugs in federal programs when three or more generic equivalents are available. The DRA methodology will use AMP to establish the FUL for generic (also known as multisource) drugs when two or more equivalents are available.

AMP has been available to CMS for years. Section 1927 of the Social Security Act (the Act)¹ established the Medicaid drug rebate program that has been in operation since 1991. The Act specified that in order for a medication to be eligible for federal Medicaid funding, the manufacturer had to enter into a rebate agreement with CMS and pay rebates to the Medicaid program. AMP is one of the components identified for establishing unit rebates for each Medicaid covered drug. This unit rebate amount information is provided to the States who in turn determine the total rebates participating manufacturers owe by multiplying the unit rebate amount by the total number of units dispensed to their beneficiaries.

The Act requires that AMP be reported to CMS by the manufacturers on a quarterly basis. AMP is defined under section 1927(k)(1) as: "The average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts".

While AMP is specifically identified in the Act it cannot be considered definitive as an indication of the price of drugs. It is only one of a variety of price indicators. AMP cannot be assumed to be the actual cost drug wholesalers pay. It is a manufacturer reported data element that is related to the average cost drug wholesalers pay to the manufacturers to make drugs available for purchase to the "retail class of trade".

The actual method of AMP calculation has been shown to vary by manufacturer. A review and report by the Office of Inspector General dated May 2006 found requirements for determining some aspects of AMP not clear and comprehensive and identified a need to improve upon the timeliness and accuracy of reporting. It also found some manufacturers' methods of calculating AMP were

¹ Section 1927 of the Social Security Act is located in Appendix 1.

inconsistent. To illustrate, the report cited the need to clarify the definition of “retail class of trade”. With this, the inclusion or exclusion of the pricing of drugs available to some such outlets can change the reported AMP. For example, while it would include retail pharmacies located in communities and available to the general population, the “retail class of trade” might also include those who may receive larger discounts on prescription medications not available to pharmacies practicing in community settings including mail order and limited service “closed shop” pharmacies; pharmacies solely serving institutions (for example, nursing homes); and pharmacy benefit managers making direct purchases and/or purchases with rebates.²

AMP does not reflect the prices paid by pharmacies to the wholesalers for the medications they stock and have available for dispensing. As a result, the DRA methodology proposes to set the FUL for pharmacy reimbursement at 250% of AMP.

AMP is not currently publicly available information. While the DRA proposes to make it public, at this time it is protected by law from disclosure. In the absence of information, pharmacies in Vermont and across the nation are concerned that the application of AMP in the calculation of FUL will result in a reduction in reimbursement for generic products.

The Office of Vermont Health Access (OVHA) administers the pharmacy benefit in Vermont’s publicly funded programs. FUL is used in establishing the reimbursement rate. Presently, OVHA reimburses based on the lesser of the following:

- the Average Wholesale Price (AWP) minus 11.9% plus the dispensing fee;
- the FUL plus the dispensing fee;
- the OVHA Maximum Allowable Cost (MAC) plus the dispensing fee; or
- the usual and customary charge (U&C) including a dispensing fee.

(At present, the dispensing fee in Vermont is \$ 4.75 for in-state pharmacies and \$3.65 for pharmacies outside the state of Vermont.)

On this basis, if the new FUL on a product proves to be less than the other pricing options there will be a reduction in the pharmacy payment.

Pharmacy concerns with the use of AMP are not limited to FUL pricing. As of July 2006, the AMP reported by manufacturers to CMS became available to state Medicaid agencies for the first time. With AMP information not readily available, some pharmacies report that they are worried that states may begin to base pharmacy reimbursements for all drugs, branded and generic, on AMP without adequately assessing the actual prices community pharmacies must pay for the medications dispensed.

² The Report of the Office of Inspector General is located in Appendix 2.

Both professional pharmacy literature and the lay press have reported that the pharmacy reimbursement model presently in place may have resulted in State and Federal programs “overpaying” for the drug portion of prescription expenses due to what may be inflated drug costs. However, pharmacies nationally report that the dispensing fees that they receive from insurers have not increased adequately and in many cases have been decreased over time. To illustrate, the 2005 National Community Pharmacists Association (NCPA) digest reported the national average dispensing cost as \$9.24. While some insurers or Medicaid programs may pay this amount for unique drugs or unique types of dispensing, no known insurers or Medicaid programs currently pay this amount as a matter of routine.

To understand the implications of the DRA and the costs of dispensing in Vermont, Act 215 of the Vermont General Assembly of the 2005-2006 Legislative Session (H.881) authorized the following:

“Sec. 107a. MEDICAID GENERIC REIMBURSEMENT REDUCTION AND DISPENSING FEE STUDY

(a) The office of Vermont health access shall conduct an impact analysis of the Deficit Reduction Act of 2005 (H.R. 4241/S.1932) on pharmacists and the Vermont pharmacy benefits program. Specifically the office shall evaluate:

(1) The impact of the generic drugs provision on Vermont pharmacists and on program participants in Medicaid.

(2) The state’s potential direct savings due to the generic drug change.

(b) The office shall provide preliminary findings to the legislative health access oversight committee and the legislative joint fiscal committee by September 1, 2006, with a final report to be submitted to the above committees by November 15, 2006.”³

While the focus of the text of this is generic reimbursement, the section heading includes the study of dispensing fees. With pharmacy business expenses being both the cost of products and the cost of dispensing, OVHA concluded that it was necessary to study all product costs for beneficiaries enrolled in Vermont’s publicly funded pharmacy programs to the extent possible.

On August 31, 2006, the Office of Vermont Health Access (OVHA) entered into a contract with the University of Connecticut School of Pharmacy (UCSOP) to advise, assist, and perform aspects of this study. To accomplish this goal, resources of the UCSOP were augmented with the services of Advanced Pharmacy Concepts (APC) as a subcontractor. Together, this team analyzed Vermont program pharmacy claims and conducted a survey of pharmacies providing services to beneficiaries of those programs.

³ OVHA requested and the committees granted an extension to submit the final report in January 2007.

In soliciting a contractor OVHA specified the following:

Scope of Work:

Minimally the project related to Vermont administered pharmacy programs will include:

1. an evaluation of current reimbursement in comparison to public and private insurers;
2. an evaluation of the frequency of generic use in Vermont programs, both in terms of generic equivalents and alternatives;
3. an evaluation of branded drug pricing options;
4. an evaluation of the generic drug pricing options;
5. a comparison of current pricing to the Average Manufacturer Price (AMP) as made available by the Centers for Medicare and Medicaid Services (CMS);
6. a comparison of current pricing to any other pricing information provided by CMS;
7. an evaluation of non-standard pricing considerations including but not limited to drugs available through mail order, drugs available through specialty pharmacies, and compound drugs;
8. an evaluation of potential program savings from reduced costs for generic reimbursement;
9. the soliciting of input from pharmacies enrolled as providers in Vermont programs;
10. an evaluation of the potential business revenue losses to pharmacies from reduced generic reimbursement;
11. a comparison of cost of dispensing information as made available by pharmacies enrolled as providers in Vermont programs; and
12. an assessment of the impact of the generic price reduction on program beneficiaries' out of pocket costs.

Significant Duties:

- pricing and utilization data analysis involving Vermont pharmacy claims;
- pricing and utilization data analysis involving all active National Drug Codes (NDCs);
- research and analysis on pricing options and models;
- the convening and management of a provider group to assist in the information gathering of this project;
- the analysis of pharmacy business costs as made available by pharmacies;
- assisting in the resolution of differences or questions concerning data or analyses; and

- the completion of preliminary and final reports detailing the process, the description and compilation of data and analysis, and the conclusions.

Project Methodology

Pharmacy Claims Analysis

To conduct the assessment of pharmacy pricing options and utilization, APC obtained detailed individual pharmacy claims for coverage under Vermont's publicly funded programs. Claims were obtained in an electronic file format that included individual claim transaction records with pharmacy identification, National Drug Codes (NDCs), product quantities, and costs.

APC assessed the data file for accuracy and completeness, verifying that data fields were uniformly populated with required information according to the data dictionary provided by OVHA's pharmacy benefits administrator (PBA) and claims processing agent, MedMetrics Health Partners (MedMetrics).

APC subscribes to Medi-Span⁴ pricing services and used these industry standard databases in the pricing and claims analysis. Medi-Span drug data files contain reference pricing information, including average wholesale price (AWP), wholesale acquisition price (WAC), and the CMS federal upper limit (CMS FUL) as reported by CMS. Using the Medi-Span file records, APC populated each claim in the OVHA transaction file with AWP, CMS FUL, and WAC prices, based on the NDC code of the claim as submitted by the pharmacy, for the date of service.

To complete the pricing assessment based on the DRA requirements, APC required Average Manufacturer Price (AMP) information. OVHA supplied this pricing information as it was provided by CMS for July and August 2006.

Because pharmaceutical prices change frequently, it was essential that the pricing comparisons be conducted during the time period that was common to all data resources.

APC received pharmacy records for 1,723,213 paid, denied, and pharmacy voided claims with a date of service between March and August 2006, the period established for the pharmacy cost of dispensing survey. Ultimately only July and August claims were used because AMP pricing data was not made available for release by CMS for dates prior to July 2006. Given this situation, analysis and comparison of pharmacy pricing was limited to claims with a date of service of July and August 2006.

Other claims were not included when conducting the pricing assessments for the following reasons:

- Only paid claims were used.

⁴ MediSpan is a registered trademark.

- Drug claims paid on behalf of Medicare Part D beneficiaries were eliminated because Vermont reimbursement for these is limited to each beneficiary's costs for each drug under his/her Medicare Pharmacy Drug Plan (PDP). Payments are not based on OVHA's reimbursement methodology.
- OVHA does not have a mail order contractor for its programs so no mail order claims were used.
- Compound claims were excluded from the overall drug pricing analysis because they are priced with logic different from other pharmacy claims. Since more than one product is necessary to make a compound drug, multiple products are included in a single claim and those products may be both brands and generics.
- Claims that appeared to have been billed for an abnormally low amount in comparison with AWP were eliminated because of the high likelihood that they were billed in error.

After parsing the data, APC retained a final working data set of 240,747 July and August claims upon which to proceed with a comparative analysis.

Pharmacy Business Cost Survey

The UCSOP reviewed contemporary literature to gather insight and knowledge pertaining to the costs involved in prescription dispensing prior to producing a draft survey for presentation to and discussion with OVHA staff and key pharmacy stakeholders. In addition, pharmacy professional associations and other surveys performed for the purposes of measuring the cost of dispensing were queried and reviewed for a better understanding of practical methods for gathering and reporting the cost components involved in the dispensing process. A number of the documents were referenced to help with the formulation of the Vermont cost of dispensing survey including documents prepared by the Center for Pharmacoeconomic Studies at the University of Texas at Austin, the National Association of Chain Drug Stores and the National Community Pharmacists Association.⁵ In addition, surveys and tools prepared by other states were also reviewed including documents from Texas, California and Maine.

Consideration was given to the complexity of accurately measuring costs once they were identified. In many pharmacy settings, business activities other than prescription dispensing occur. While the business as a whole may accumulate and pay for expenses as a single unit, for the purposes of this analysis, procedures were needed to measure that portion of those expenses that could be accurately attributed to the prescription dispensing activities. To illustrate, a pharmacy may have within its location a space equal in size to the prescription department dedicated to the sales of over-the-counter medications. While it is fair to calculate a way to allocate expenses such as taxes and rent based on the relative areas of the two departments, other expenses needed to be allocated

⁵ A sample of documents referenced is included in Appendix 3.

based on such things as the relative sales or the relative payroll expenses the two departments experienced. Methods and strategies were developed and implemented to calculate reasonable estimates to allocate expenses incurred by the whole pharmacy operation to come as close as possible to calculating all the expenses that could be directly attributable to the prescription dispensing segment of the business while eliminating those expenses that had no bearing on that activity.

Beginning and ending dates of the business period for the survey had to be established. Ideally, this period had to be uniform for all respondents, recent enough to be as close as possible to present conditions, representative of typical business conditions and long enough to minimize as best as possible variations due to seasonal or extraordinary events. Finally, the study period had to meet all of these criteria while allowing a reasonable amount of time to gather and report the data.

The decision was made with staff at OVHA to select the time period of March 1 through August 31, 2006. The Coalition for Community Pharmacy Action (CCPA) formed through the joint efforts of the National Community Pharmacy Association (NCPA) and the National Association of Chain Drug Stores (NACDS) created and released a nationwide survey on October 17, 2006 using the same study period.

In September 2006, the survey tool was developed to gather all the needed data elements in a way that made the process as simple and straightforward as possible for the pharmacies. This had importance for at least two reasons. First, a goal of the survey was to collect as many complete and usable responses as possible. Second and closely related, time limitations necessitated a survey tool that could be completed, returned, and analyzed within the period available.

A meeting was held at the OVHA office in Williston, Vermont on September 18, 2006 to discuss the draft survey tool with pharmacy stakeholders. Present at the meeting representing practicing pharmacists was Anthony Otis, Legislative Liaison for the Vermont Pharmacists Association. Participating in the meeting via telephone were Brian Bruen, Director, Policy Studies and Research for the NACDS and Philip O'Neill, a Vermont pharmacy owner. The survey draft was discussed and a number of suggestions were made to improve the tool.

A revised draft was prepared and disseminated to the meeting participants for final comments and suggestions. On September 26 the final survey data collection tool and instructions were approved by OVHA and plans were made to produce and mail the surveys.

On September 28 survey forms and instructions were mailed to the attention of pharmacy managers of each of the pharmacies identified by OVHA.⁶ The

⁶ A survey tool, cover letter, confidentiality letter and instructions are located in Appendix 4.

pharmacy managers of pharmacies located in states other than Vermont with a history of providing pharmacy services to residents of Vermont were also mailed a survey packet. Generally, these are pharmacies located in states bordering Vermont. Pharmacies that appeared to have no consistent usage and were not located in Vermont or a contiguous state were not mailed a survey packet. In total, 232 surveys were mailed. Of the total survey packets mailed, 146 were to in-state pharmacies.

In addition to each mailing made through the postal system, survey forms and instructions in an electronic format were emailed to Anthony Otis and Brian Bruen as a way to facilitate timely delivery. A version of the survey tool designed to facilitate reporting by companies operating multiple pharmacy outlets was prepared and this was emailed to persons identified by Mr. Bruen as people employed by these companies who could help facilitate the survey reporting process.

On October 3, an evening conference call was arranged by Anthony Otis and Brian Bruen for the purpose of introducing the cost of dispensing survey to the pharmacists of Vermont and facilitating their support of and participation in the process. The call began with an overview of the survey tool and instructions, followed by a question and answer period. An estimated 25 to 30 pharmacists participated in the call. As a result of this call, a change was made to the survey tool to clarify issues regarding primary payment source for the purposes of statistics. A follow up email communication noting the clarification was prepared and disseminated. A concern was also raised with regards to the confidentiality of the sensitive proprietary business data being asked for in the survey process. To address these concerns, a letter was drafted, reviewed and disseminated by OVHA to the pharmacists.

Survey responses were due back at the UCSOP by October 20.

On October 11 a reminder post card was mailed to each of the pharmacy managers. The first completed survey response arrived on October 13. Allowing for possible delays due to potential mail delays, survey responses received as late as November 10, 2006 were included in the analysis.

Report of Findings from Claims Analysis

For the purpose of any claims analysis, the definitions found in the Acronyms, Definitions, and Identifications found on page 1 of this report have been used. All Vermont expenditures represented are gross payments, including both state and federal portions of cost. All payments are before the collection of any manufacturer rebates.

Evaluation of Current Reimbursement

The Vermont program reimbursement during the audit time period was the lower of the pricing methods indicated below:

PHARMACY TYPE	DRUG REIMBURSEMENT	DISPENSING FEE
In Vermont	AWP – 11.9%	\$4.75
In Vermont	CMS FUL	\$4.75
In Vermont	OVHA MAC	\$4.75
In Vermont	U&C/Submitted	Included in U&C/Submitted
Out of Vermont	AWP – 11.9%	\$3.65
Out of Vermont	CMS FUL	\$3.65
Out of Vermont	OVHA MAC	\$3.65
Out of Vermont	U&C/Submitted	Included in U&C/Submitted

With no mail order contractor, OVHA does not have differential pricing between retail pharmacies and contracted mail order pharmacies. Thus, there were no such mail order pharmacy claims during the assessment time period.

The review was applied to the 240,747 July and August claims available for comparison. The following pricing options were considered on each claim:

- the pharmacy reported U&C/submitted on the date of service adjusted by the amount of the Vermont programs' dispensing fee to arrive at the reported cost of the product
- the AWP for the product reduced by 11.9% on the date of service
- the OVHA MAC for the product on the date of service
- the CMS FUL as applied on the date of service

Each claim was then "priced" for the purposes of this analysis at the lower of the options.

Evaluation of Branded and Generic Pricing

Overall Pricing

Based on the claims review, APC determined that the overall discounts against AWP achieved in Vermont publicly funded programs were as follows:

	Claims	VT paid IC	AWP	Discount
Brand	90,635	\$14,356,176	\$16,297,663	11.913%
Generic	150,112	\$2,884,677	\$7,686,918	62.473%

While OVHA prices branded drugs at AWP minus 11.9%, the slightly higher discount found in claims can be further assessed by reviewing the “basis of cost” that was applied to individual claims for payment purposes.

Branded Pricing

The chart below indicates the 11.913% discount was achieved on claims that were paid on differing basis of cost. Certain brand medications were paid at a cost basis other than solely AWP:

- In some cases branded drugs were actually paid at the pharmacy’s usual and customary charge.
- In other cases a brand was priced at the generic OVHA MAC or the CMS FUL. While MAC and FUL are usually applied to generic claims, they are the basis of payment for a small number of brand claims when a pharmacy is using a brand product as its “house” generic. In this situation, a pharmacy purchases a brand drug at a discounted price that is comparable to the price of its generic equivalents. When the brand has two or more generic equivalents, the pharmacy receives the generic rather than brand reimbursement.
- On occasion Medi-Span updates AWP prices retrospective to the actual effective date of the price change. This practice results in slight variation in actual AWP discount performance. The Vermont results based solely on AWP are within the level of variation that is expected due to such retroactive price changes.

	Claims	VT paid IC	AWP	Discount
Brand Breakdown				
U&C	2,025	\$218,166	\$247,586	11.883%
Submitted Cost	31,592	\$4,924,823	\$5,589,114	11.885%
OVHA MAC	333	\$5,253	\$11,343	53.684%
CMS FUL	37	\$317	\$558	43.227%
Discount off AWP	56,648	\$9,207,617	\$10,449,062	11.881%

Generic Pricing

An analysis of generic claims on the basis of cost is also possible. OVHA MAC and CMS FUL prices are applied only to those generic medications that are manufactured and/or distributed by multiple manufacturers. For the July and August period of analysis, MAC and FUL prices were available when there were three or more generic equivalents available. When the generic used was a single source generic product or a generic where only two equivalents were

available, payment would have been based on usual and customary/submitted rates or the AWP discount.

	Claims	VT paid IC	AWP	Discount
Generic Breakdown				
U&C	2,743	\$60,965	\$100,193	39.153%
Submitted Cost	15,424	\$357,633	\$535,226	33.181%
OVHA MAC	99,543	\$1,903,173	\$5,654,027	66.340%
CMS FUL	23,563	\$153,523	\$932,789	83.542%
Discount off AWP	8,839	\$409,384	\$464,683	11.900%

OVHA MAC/CMS FUL Pricing

In many reimbursement models, CMS FUL prices achieve a discount between 65% and 70% off AWP, depending on the mix of products dispensed. OVHA's CMS FUL performance in July and August was higher because the FUL was only applied when the price was lower (discount was higher) than the OVHA MAC price. The combination of both the CMS FUL and OVHA MAC demonstrates the total Vermont program discount at 68.776%.

	Claims	VT paid IC	AWP	Discount
OVHA MAC	99,543	\$1,903,173	\$5,654,027	66.340%
CMS FUL	23,563	\$153,523	\$932,789	83.542%
Total of MAC and FUL	123,106	2,056,696	6,586,816	68.776%

Evaluation of Generic Usage in Vermont Programs

APC evaluated generic dispensing in the OVHA programs. Use of generic products has been seen to be the single most valuable cost-saving initiative that can be implemented by any insurer.

Generic dispensing rates can be expressed in a variety of ways. The "generic dispensing rate" is a term used to refer to the number of prescriptions dispensed using generic medications as a percentage of all prescriptions dispensed. Not all drugs have generic equivalents available. The "generic substitution rate" is a term used to refer to the number of prescriptions that are dispensed with a generic medication when an equivalent generic version of the drug is available. Generic versions of medications are only available when a brand (innovator) medication has lost patent protection. In general, generic dispensing reflects the extent to which generics are used in a program, while generic substitution represents both the prescribing instructions of the physicians and other prescribers and the dispensing practices of the pharmacies.

The generic dispensing rate for the covered populations in Vermont's programs has been somewhat consistent in the last year. For the fourth quarter of calendar year 2005, the last quarter prior to Medicare Part D implementation, the

generic dispensing rate was 61.37%. For the quarter ending June 30, 2006, the rate was 61.47%. In this project's 240,747 claims during July and August 2006, the rate was 62.4%.

For this analysis, both drugs characterized as generics (Y designation) and branded drugs available from multiple manufacturers (referred to as "multisource drugs"; M designation) are used in the calculation of generic substitution.

In December 2005, the overall generic substitution rate for all generic claims when a generic equivalent was available was 97.7%. This is exactly the rate in the July/August 2006 claims.

To recap, the following chart identifies generic usage in Vermont's publicly funded programs:

Jul – Aug 2006	Percentage of Rx
Generic use as a percentage of all drugs dispensed	62.4%
Generic use when generic equivalent available	97.7%

In the experience of APC, these Vermont program generic indicators are excellent for their respective categories when compared to commercial drug benefit programs.

That success is a tribute to Vermont's generic drug law at 18 V.S.A chapter 91 where pharmacies dispense generics unless the prescriber expressly requires the brand. It can also be attributed to the activities of the Vermont Best Practices and Cost Containment Program established by 33 V.S.A. chapter 19, subchapter 5 and the program's Drug Utilization Review Board that serves as the pharmacy and therapeutics committee for OVHA.

Comparison of Current Pricing to Average Manufacturer Price (AMP)/ Potential Savings from Reduced Costs for Generic Reimbursement

APC compared OVHA's current drug pricing and AWP pricing to the AMP prices that were supplied by CMS to OVHA for July and August 2006.

AWP is reported based on the NDC code of each strength and package size of medication, and prices may differ between packages. AMP is reported for each drug dosage form and strength, regardless of package size. To conduct an assessment of brand pricing, APC used the AWP prices reported for each product by NDC code and compared prices to the actual AMP as reported by CMS for that particular drug on a claim by claim basis.

In addition, assessment of generic drug prices required additional consideration. OVHA MAC and CMS FUL prices were determined through a formula that takes

into account the list prices for a specific drug strength and dosage for all manufacturers that supply the product to the market.

The CMS FUL as currently available applies only when three or more generic equivalents are available. Under the DRA, the CMS FUL will be calculated when there are two or more equivalents. To duplicate the reimbursement levels established in the DRA, APC created a “FUL”-like price using AMP for generics with two or more manufacturers. To further duplicate the DRA methodology, APC applied the lowest AMP reported by any manufacturer for all “like” generic drugs as the basis for calculating the AMP. For example, if five manufacturers each make the same dosage form and strength of a particular medication, they report their AMP for that particular generic drug/strength. The lowest of the reported five prices is used as it would be by CMS applying DRA requirements.

	Claims	AWP	VT paid IC	Current Discount	Proposed VT paid IC with AMP at 100%	Discount at 100% AMP	AMP at 250%	Discount at 250% AMP
Brand	90,635	\$16,297,663	\$14,356,176	11.9%	\$11,794,995	27.6%	\$29,487,488	-80.9%
Generic	150,112	\$7,686,918	\$2,884,677	62.5%	\$493,274	93.6%	\$1,233,185	84.0%
Generic: No OVHA MAC/CMS FUL	27,006	\$1,100,101	\$827,982	24.7%	\$158,956	85.6%	\$397,389	63.9%
Generic: OVHA MAC/CMS FUL	123,106	\$6,586,817	\$2,056,696	68.8%	\$334,318	94.9%	\$835,796	87.3%
Total VT paid IC	240,747	\$23,984,580	\$17,240,854	28.1%	\$12,288,269	48.8%	\$30,720,673	-28.1%
VT paid IC per Rx			\$71.61		\$51.04		\$127.61	

As noted in the above chart, AMP prices are inherently considerably lower than AWP. Using 100% of AMP in place of the current AWP discounted rate on brands would result in a discount of 27.6% as compared to 11.9% off AWP prices based on the drug mix and volume assessed from the OVHA claim sample for July and August 2006. It would also create a discount on all generics. For this two month claim sample the reduction would be nearly \$5 million. The actual amount would depend on market share and prescribing habits, but a per claim decrease of anywhere from \$17 to \$21 across all prescriptions might be expected.

100% of AMP represents the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. In turn the wholesalers set prices to sell the products to pharmacies. Those prices are not available for this analysis but they are certainly not equal to AMP, markups would be expected. Conceptually the DRA methodology of setting the new CMS FUL at 250% of

AMP is at least partially in recognition of that. However, applying 250% to AMP has a very different effect on generics than it does on brands.

Comparing the current reimbursement to the AMP at 250% on the 150,112 prescriptions filled with generic medications results in a reduction in spending of \$1.7 million with a per prescription variance of \$11 for the two month period of analysis. Looking at brand drugs and applying the same 250% methodology results in prices that significantly exceed their AWP prices. This would result in a program reimbursement increase on brands of \$15.1 million based on that two month period.

Potential Pharmacy Revenue Losses from Reduced Generic Reimbursement

Any reduction in program spending based on AMP results is a loss in revenue to community pharmacies. The actual amount is impossible to assess at this time.

The CMS proposed rule to implement the provisions of the DRA pertaining to prescription drugs was published on December 22, 2006. Interested parties have until February 20, 2007 to review and comment. While federal rules are effective as proposed during the comment period, formal questions and comments submitted must be addressed by CMS and changes are likely. At this point it is unknown when the FUL will fully reflect the effect of the use of AMP.

Thus, a true estimation of any related reduction in generic reimbursement is not possible.

Assessment of the Impact of Generic Price Reduction on Program Beneficiaries' Out of Pocket Costs

In Vermont programs, only traditional Medicaid eligibles currently have cost sharing. That cost sharing is in the form of copayments and the amounts depend on the cost of the drug to the Medicaid program as established applying OVHA's pricing methodology:

- \$1.00 for prescriptions costing \$29.99 or less
- \$2.00 for prescriptions costing \$30.00 to \$49.99
- \$3.00 for prescriptions costing \$50.00 or more

If a drug is priced at a lower amount because of AMP and thus the related CMS FUL, a beneficiary may experience a savings of \$1 or \$2 per drug depending on the resulting difference in pricing.

Comparison of Current Pricing to Other Pricing Information

While CMS has not provided any other pricing information in the course of this study, additional information is available on pricing related matters.

340B

The federal 340B Drug Pricing Program makes reduced price prescription drugs available to health care facilities certified by the U.S. Department of Health and Human Services (HHS). Under the 340B Program, the discounted drugs are obtained from manufacturers at a negotiated price that can be comparative to the Medicaid price net of the national federal Medicaid rebates. Under 340B regulations the drugs are not additionally subject to Medicaid rebates since the manufacturer provides the 340B discount.

The 340B Program provides a significant service in the community. However, drugs provided under the Program do not reduce Medicaid spending. Pricing methodologies used in Vermont programs pay 340B facilities exactly as they do all pharmacies without any adjustments. Facilities certified to dispense 340B drugs are not obligated to share their discount with Medicaid when drugs are dispensed on behalf of Medicaid beneficiaries. Unless 340B facilities bill the Vermont Medicaid programs at a price at least equal to their discount, Vermont actually pays more for 340B drugs than drugs obtained in community pharmacies.

Possible Changes in the Use of AWP in Pricing

In October 2006 the United States District Court, District of Massachusetts ruled on a nationwide lawsuit brought by private insurers against First Databank, Inc. (FDB), a source of prescription drug data and prices in the United States (C.A. No. 1:05-CV-11148-PBS). The suit alleged that First Databank conspired with a leading prescription drug wholesale provider, the McKesson Corporation, to arbitrarily increase the markups between what pharmacies pay wholesalers for prescription drugs through the setting and publishing of AWP. This AWP as published by First Databank and then referenced by major pricing services like Medi-Span is used by many insurers to calculate pharmacy reimbursements for many prescription drugs. AWP is used in Medicaid pricing by forty-eight states and the District of Columbia.

In the settlement of this case FDB agreed to adjust published prices. The projected date of this adjustment is spring 2007. While there is no retroactive adjustment available to public programs like those in Vermont, there will be an impact in the future in the form of a reduction in reimbursement on brand drugs that have been priced based on AWP. Estimates vary from 4-5%. Using the two month claims period available from the claims analysis, the following table estimates a potential two month impact based on 4%:

	Claims	AWP	VT paid IC	Current Discount	AWP reduced by 4%	VT paid IC with 11.9% discount on reduced AWP	Change in VT paid IC
Brand	90,635	\$16,297,663	\$14,356,176	11.9%	\$15,645,756	\$ 13,783,911	\$572,265

OVHA MAC

The OVHA maximum allowable cost (MAC) is applied to generics when three or more generic equivalents (AB rated) are available. The MAC price is established based on the prices of the products as readily available. The use of a MAC list discourages the use of the more expensive generic equivalent alternatives.

WAC

A pricing option used by insurers not otherwise addressed in this project is Wholesale Acquisition Cost (WAC).

Wholesale acquisition cost (WAC) is reported by pharmaceutical manufacturers and represents the “list” price for which a pharmaceutical product is sold to the wholesaler. Actual sale prices are often lower, reflecting contractual terms, payment discounts, and other incentives offered by manufacturers to wholesalers. WAC is often considered the cost basis that is used by pharmaceutical wholesalers for sales to retail pharmacies. Pharmacy purchase prices are commonly in a range that is a few percentage points above or below WAC price, based on payment terms and incentives.

Several state Medicaid programs, including Rhode Island and Massachusetts, have adopted WAC pricing as a basis of payments to pharmacies. To demonstrate the financial impact of this option to OVHA, APC assessed WAC prices against current discounted drug pricing and to AWP pricing that is listed in Medi-Span using NDC codes submitted by the pharmacies. Because WAC price reporting is voluntary, a WAC price is not available for some products. In assessing OVHA’s 240,747 available claims from July-August 2006, WAC price could be determined for only 225,961 claims. The table on the following page outlines the results of this analysis:

	Claims	AWP	VT paid IC	Current Discount	Proposed IC with WAC at 100%	Discount at 100% WAC
Brand	88,990	\$16,190,852	\$14,262,279	11.9%	\$12,934,828	20.1%
Generic	136,971	\$7,146,132	\$2,595,597	63.7%	\$3,524,921	50.7%
Generic: No OVHA MAC/CMS FUL	114,345	\$6,249,458	\$1,938,649	69.0%	\$2,932,875	53.1%
Generic: OVHA MAC/CMS FUL	22,626	\$896,675	\$656,948	26.7%	\$592,046	34.0%
Total VT paid IC	225,961	\$23,336,984	\$16,857,876	27.8%	\$16,459,749	29.5%
VT paid IC per Rx			\$74.61		\$72.84	

Comparison to Public and Private Insurers

The Vermont Medicaid AWP reimbursement on brands is higher than the rate used by the other New England states and by the state of New York. Massachusetts and Rhode Island both use WAC at a rate that results in a lower reimbursement. Maine, New Hampshire, Connecticut, and New York use AWP discounts that range from 12.75% to 16%.

The Vermont program brand reimbursement is higher than commercial insurers. On average, PBMs and commercial insurers obtain AWP discounts of 15.4% for brand medications dispensed in retail pharmacies in the Northeast.⁷ Using the drug analysis on the 240,747 claims where the Vermont programs paid \$14.4 million dollars for branded drugs in July and August 2006, the estimated result of a change in the brand discount rate from the current rate of AWP – 11.9% to AWP -15 % would lower the amount paid for those two months by \$400,000.

The current Medicaid discounts achieved by OVHA for generic drug prescriptions are as deep as or deeper than those obtained by other insurers. These savings are largely associated with the established OVHA MAC program. Its results are comparative to those of Massachusetts Medicaid which uses a similar MAC methodology. They exceed those produced in Medicaid in the other New England states and in the state of New York. The other states use WAC or current CMS FUL for generic reimbursement. OVHA's discount may actually exceed the discounts obtain by commercial benefit programs.

⁷ Takeda Prescription Drug Benefit Cost and Plan Design Survey Report, 2006 edition (New England and New York)

Evaluation of Non-Standard Pricing Considerations

Mail Order Pharmacies

Mail order pharmacies are commonly used by many insurers for beneficiaries with maintenance needs for drugs. Brand discounts for prescriptions filled in mail order pharmacies are higher than those offered in retail pharmacies. In general, brand discounts range from 21% to 23%.⁸

Two major issues exist with mail order pharmacies, waste and access. Mail order pharmacies generally dispense 90 day supplies. Savings may be reduced by an increase in drug waste when drugs dispensed are not used⁹. Coverage design must be carefully planned to minimize this. Assuring accessibility means that savings may only apply to a portion of an insurer's business. To assure accessibility, some insurers have opted to create networks of local pharmacies that contract to provide 90 day supplies of defined drugs at prices comparative to mail order pharmacies.

Specialty Pharmacies

Specialty pharmacies provide a product or products intended to treat specific issues. Common are:

- Diabetic supplies
- Multiple sclerosis drugs
- Growth hormone drugs
- Hemophilic drugs
- Unique treatment drugs (for example, Synagis® used to treat respiratory syncytial virus, a respiratory ailment unique to newborns that are born prematurely).

For drugs as opposed to diabetic supplies, savings are realized because the cost to have products available may be less for pharmacies who order in sufficient quantities to benefit from discounts. In some cases best savings are likely to be found when contracting with a pharmacy or even a manufacturer based on a drug or drugs to treat a single condition. Amounts are impossible to predict as they are dependent on individual contracts. Actual drug savings may be reduced by options offered by specialty pharmacies but the options may result in better product use and/or health outcomes; for example, counseling.

In the case of products with broad use like diabetic supplies, specialty pharmacies may be an option but it may also be possible to obtain greater savings through supplemental rebate contracts directly with the manufacturer(s). The latter assures that the products remain readily available in the community.

⁸ IBID

⁹ American Journal of Health-System Pharmacy. 58(13):1190-1191, July 1, 2001

Compound Drugs

Compound drugs present challenges to all insurers in the management of the pharmacy benefit. At the direction of a prescriber, a compound drug is one made by a pharmacy by combining a drug or drugs and/or other ingredients to create a unique drug and/or method of administration.

Compound drugs are a small portion of Vermont publicly funded pharmacy programs. In state fiscal year 2006, a total of \$275,211 was paid for compound drugs in comparison to a \$168 million drug spend. With the implementation of Medicare Part D coverage on January 1, 2006 and the transition of 30,000 Vermont program beneficiaries to Part D as primary coverage, the number of compound drug claims has decreased. In calendar year 2005, 4,920 compound drug claims were paid out of a total of 3 million claims. In calendar year 2006, there were 3,632 compound claims out of 2.4 million claims.

Compound drugs were excluded from the claims analysis of pricing in this report because they are priced with logic uniquely different from other pharmacy claims. Since more than one product is necessary to make a compound drug, multiple products are included in a single claim and those products may be a combination of brand and generic entities.

Vermont Medicaid policy at M813.3 allows for the payment of compound prescriptions based on the “lower of the actual amount charged or the price of ingredients plus the dispensing fee plus a compounding fee on file for each minute directly expended in compounding.” The fee for each minute is \$.35.

Prior to 1993 pharmacies submitted claims for compound drugs using paper claims. By late 1993, most all other pharmacy claims could be submitted electronically. There was a significant advantage in electronic claims. Paper claims took as much as 30 days to process to payment. Approved electronic claims paid within two weeks and sometimes within one.

In an effort to expedite payment on compound claims, pharmacies were allowed to use a single NDC-like code to bill for ingredients and time. Initially they were allowed to bill for claims up to \$20. Claims over \$20 required a paper claim indicating the specific ingredients and minutes. This threshold was subsequently raised to \$50 and \$100 in recognition of increasing ingredient costs.

The Deficit Reduction Act of 2005 expressly requires the full identification of all drug ingredients. With the implementation of a new claims processing system as of January 1, 2006, it was possible to electronically bill based on individual ingredients. In turn, those ingredients were paid based on the pricing methodology for each product. Initially the standard dispensing fee was paid: \$4.75 for in-state pharmacies, \$3.65 for out-of-state pharmacies. However, this

did not provide any reimbursement for time compounding. OVHA began paying \$5.25 for each compound claim over and above the standard dispensing fee. This amount is equal to an estimated average time of compounding of 15 minutes at \$.35. Pharmacies have indicated that that is insufficient.

A survey of Medicaid states in March 2006 resulted in twenty-five responses. Nineteen states paid for compound drugs with no additional dispensing fee. Two paid an additional fee of less than \$5. Three paid fees based on varied methods.

Certainly applying a single fee is administratively simpler for claims submittal and processing for all concerned. For some pharmacies with varied compound drugs, this aggregate approach is adequate. However, depending on the type of compounding, some pharmacies may be overpaid while other pharmacies are underpaid. At issue is the level of effort and/or degree of difficulty in preparing the compound product.

Some private insurers apply the same approaches as Medicaid programs. Others recognize some degree of effort and difficulty. The National Council for Prescription Drug Programs, Inc. (NCPDP) sets the standards for electronic drug claims processing. NCPDP does not include standards for time increments but does allow for up to 5 levels of effort in compounding drugs that can be premised on time. Allowing for such levels assures that pharmacies are reimbursed for their specific efforts in compounding drugs.

Many PBMs/PBAs and pharmacy insurers set requirements to address adequate clinical and financial management of compound drugs. Criteria address certain expectations. Prior authorizations are commonly required or compounds are subject to post payment review such that claims are disallowed for failing to meet the criteria. Some criteria examples include:

- the safety and effectiveness of the compound and its prescribed use must be supported by medical and scientific evidence found in peer-reviewed studies, medical journals, peer-reviewed literature, biomedical compendia, and other medical and pharmacological literature;
- compounds cannot be substitutions for combinations of over-the-counter products; one or more prescription ingredient must be included in the compound;
- all prescription ingredients must be FDA approved for medical use in the United States;
- the compounds may not be a copy of a commercially available FDA approved product; and
- the compound may not be a substitution for a readily available FDA approved product.

Vermont's Pharmacy Fee

On July 1, 2005, Vermont pharmacies began paying a per prescription fee to the state in support of publicly funded health insurance programs. For every prescription filled, regardless of payer, the pharmacy pays \$.10 per claim.

For state fiscal year 2006, Vermont pharmacies paid a total of \$748,733 through January 7, 2007. For the first quarter of state fiscal year 2007 the amount paid was \$193,924 through the same date.

Medicare Part D

With the implementation of drug coverage under Medicare Part D, 30,000 people were transitioned from Vermont programs to Part D for primary pharmacy coverage. At the same time as many as 60,000 other Medicare eligibles became potentially eligible for Part D. From a pharmacy business position, Part D meant Part D Prescription Drug Plan (PDP) payments and cost sharing replaced payments from Vermont's programs and uninsured customers.

Generic Drug Discount Programs

In the fall of 2006 major national retail outlets announced generic drug discount programs. Since that time other department and food stores with pharmacy departments have begun or are considering similar programs. These programs do not apply to all generics. Each uses a specific list of generics. Vermont examples are Wal-Mart and Price Chopper.

In the case of Wal-Mart, the program is available to anyone for select generics for \$4 for 30 units. Initially this was reported as 30 days but it has now been amended to "up to" 30 days. This price is available to Vermont publicly funded programs. However, the programs only benefit from the price if beneficiaries can readily access the stores.

Price Chopper offers a 100 unit program for \$10. It is only available to customers who pay cash; Price Chopper will not bill any insurer including Vermont's programs.

While representatives of these stores report that they do not lose money on their programs, some observers believe that their purpose is to increase the stores' other retail business. Thus, the price offered may or may not reflect what other pharmacies can offer.

Report of Findings from Cost of Dispensing Survey

Copies of the pharmacy survey cover letter, survey collection tool, and survey instructions can be found in Appendix 4.

The following summarizes surveys mailed and the response rate:

	Vermont In-state Pharmacy	Out-of-state Pharmacy	Total
Pharmacy Mailing list	146	92	238
Surveys Mailed	146	86	232
Surveys undeliverable	1	1	2
Total responses	69	2	71
Usable responses	62	0	62
Response rate	47.6 %	2.4 %	29.8 %
Usable response rate	42.5 %	0 %	26.1 %

In total there were 71 survey responses received. Of these, 7 of the responses were either flat refusals to participate or were not usable because data was not supplied in the requested format. Follow up contact to clarify or better organize the data on these 7 was unsuccessful.

All survey responses received were reviewed and checked for completeness and reasonableness. Not all survey responses were received with sufficient information or lacked adequate detail to be included in the final results. To the extent possible, surveys lacking complete information and requiring clarifying information were flagged and the appropriate people at the pharmacies were contacted for the purpose of obtaining the needed information. The flexibility of the data collection team to process data, look for problems and implement strategies to address them was a factor that helped increase the response rate. As a result, survey responses were processed and adjusted well beyond the stated due date of October 20, 2006 and continued up through November 10, 2006.

One of the largest areas of reporting difficulty was with respect to line 41 regarding "Sales taxes paid". The intent of this question was to gather the expenses pharmacies incurred in the process of buying items or services for the operation of their pharmacies. Upon review, it appears many pharmacies reported the sales tax they collected and forwarded to the State of Vermont in the process of their business sales. Using the rationale that the sales taxes would be reported in the other lines of the survey tool as a part of those cost components, the decision was made to eliminate this data element from the analysis.

Another area of difficulty in analyzing responses came from some companies with multiple outlets who aggregated survey data. In some cases, a number of different pharmacy locations were reported as a whole and in some cases, a company chose to report different cost line items as a group or all encompassing number. As survey directions and accuracy of the process made clear the need to separate such data, attempts were made to contact these companies and work with them to break the data into the pieces needed. The attempts were met with mixed results. For that reason, usable survey responses were lower than the total number of responses.

The responses were primarily from retail pharmacies; that is, those with stores in the community. No mail order pharmacies have contracts with OVHA. While six of the survey respondents indicated they provided pharmacy services to patients in long-term care settings, only one of the respondents indicated that was its sole pharmacy activity and that they did not serve “walk-ins”.

Responses came from independently owned pharmacies as well as those operated by national or regional pharmacy companies. As such it is believed that the data adequately represents the practice of community pharmacy in the state of Vermont.

Two pharmacies responding to the survey supplied data yielding costs of dispensing well outside that of the other pharmacies. In both cases, these responses were treated as outliers and they were not included in the calculations.

There was a lack of response from pharmacies located outside of Vermont. With the exception of one pharmacy, there were no responses from the many pharmacies located beyond Vermont’s border. With adequate response, the data could have been a useful tool to perform comparative analysis between different practice types and locations.

The following table summarizes the findings based on the responses of the pharmacies who returned the survey with adequate data:

Mean average cost of dispensing for the pharmacies	\$10.55
Median cost of dispensing for the pharmacies	\$10.01
Reported highest cost of dispensing	\$20.75
Reported lowest cost of dispensing	\$ 7.19
Standard deviation	\$ 2.32

Average hours pharmacy open	67.7
Annualized average number of prescriptions (total)	68,108
Annualized average number of prescriptions billed the OVHA	13,933

The \$10.55 average derived in this study is comparable to the recently published 2006 NCPA Pfizer digest study that reported an average cost of dispensing for the northeast United States of \$10.19, a 3.5% variance. The 2006 study is a 9.32% increase over the 2005 NCPA study reported national average dispensing cost of \$9.24. It should be noted that the data used for both NCPA studies is somewhat older than this study and consisted of states in the northeast region of the United States which includes New York, New Jersey, Delaware, Maryland, and Virginia in addition to New England.

As indicated, this \$10.55 was arrived at based on reports from Vermont pharmacies. Currently, in establishing reimbursement, \$4.75 is applied for each script dispensed at a Vermont pharmacy when Vermont programs are the primary pharmacy insurer. \$4.75 is also used in calculating reimbursement when Vermont programs are secondary to all insurers other than Medicare Part D Prescription Drug Plans (PDPs). A fee is used in establishing payments with Medicare Part D coverage when a drug is covered by Medicaid but excluded from coverage by Medicare. No Vermont dispensing fee is considered or paid when Medicare Part D coverage is primary for Medicare covered drugs; reimbursement is limited to PDP cost sharing as allowed under Vermont VPharm rules.

The effective date of \$4.75 as the Vermont dispensing fee was July 1, 2005. Prior to that date the fee was \$4.25. In state fiscal year 2006 this increase alone is estimated to have generated over \$1.3 million in revenues to Vermont pharmacies. With the transition of many Vermont program beneficiaries to Medicare Part D, there has been a reduction in claims volume for which a dispensing fee is paid. However, it is estimated that the increase was still worth \$278,378 in the first quarter of state fiscal year 2007.

For comparison purposes, the \$4.75 dispensing fee for OVHA programs to Vermont pharmacies is greater than all other states in New England where the Medicaid dispensing fees range from \$1.75 to \$3.40 and greater than the state of New York where the Medicaid dispensing fees are \$3.50 for brands and \$4.60 for generics.

Conclusions

This study assessed the potential impact of the Deficit Reduction Act of 2005 on Medicaid generic reimbursement. However, at this time the final federal requirements have not been established. Thus, the effect cannot be determined.

The study found that Vermont programs are paying less than cost in reimbursement for dispensing.

Regarding Vermont programs' drug reimbursement the results are:

1. Vermont's current dispensing fee for in-state pharmacies is the highest dispensing fee of any New England Medicaid program for any pharmacy. That fee is also higher than the dispensing fees of New York Medicaid.
2. The price currently paid for brand drugs by OVHA programs is Average Wholesale Price reduced by 11.9% (AWP minus 11.9%). That is a higher price than paid by pharmacy benefit managers (PBMs) and commercial insurers in the Northeast where discounts against AWP are as much as 15.4%.
3. The Vermont Medicaid AWP reimbursement on brands is higher than the rates used by the other New England states and by the state of New York.
4. The Maximum Allowable Cost (MAC) discount/reimbursement structure for generics used by OVHA often pays less than the CMS Federal Upper Limit (FUL) generic reimbursement method commonly used by Medicaid programs in the region.
5. The OVHA MAC reduces payments more frequently than the current federal CMS FUL generic reimbursement model. With payments on generics based on the lesser of OVHA MAC, CMS FUL, usual and customary (U&C) charge, or AWP minus 11.9%, the frequency of use in this report's claims sample was OVHA MAC 66.3%, CMS FUL 15.7%, U&C 12.1%, and AWP pricing 5.9%. Thus the OVHA MAC is more commonly less than the CMS FUL and, when it is, it results in lower payments on generics than the CMS FUL.
6. The DRA proposes to set the CMS FUL at 250% of the AMP. At that level, Vermont overall program costs would be less for generics assuming that the AMP rates available in July and August of 2006 are representative of the AMP rates as they will be used in calculating the CMS FUL.
7. While the use of AMP pricing logic for brand name medications is not called for under the DRA, at 250% of AMP the Vermont program reimbursement would increase on brands.
8. Wholesale Acquisition Costs (WAC) is considered a measure close to actual cost. OVHA currently pays more than WAC on brands but less than WAC on some generics.

In summary, Vermont publicly funded programs are paying:

- less than reported cost in the reimbursement for dispensing,
- more for dispensing than other Medicaid programs in New England and in the state of New York,
- more for brands than PBMs and other insurers in the Northeast region and Medicaid programs in other New England states and in New York state,
- more than WAC, a measure considered close to actual cost, on brands but less than WAC on some generics, and
- generally less than the generic reimbursement used by Medicaid programs in the region.

Pharmacy business is both cost of dispensing and cost of products. The cost of dispensing is known.

Current reimbursement to pharmacies is better than other insurers and Medicaid programs in the region on brands. Current generic reimbursement while low compared to regional Medicaid programs is more likely, as a result, to be closer to the DRA CMS FUL when calculated based on AMP at 250%. That means that generic reimbursement changes in Vermont programs as a result of the DRA may not be as dramatic as they may be in other states.

Many changes are underway that may affect the reimbursement for products. Those changes and their resulting impact cannot be fully determined at this time.

As a result, it is premature to make any conclusions on the need for revisions in reimbursement.

Appendices

1. Federal regulation: the Social Security Act, Title XIX (Medicaid), Payment For Covered Outpatient Drugs per Section 1927 (42 U.S.C. 1396r-8) as found at http://www.ssa.gov/OP_Home/ssact/title19/1927.htm
2. Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005, Report of the Office of Inspector General, Dated May 2006 as found at <http://oig.hhs.gov/oas/reports/region6/60600063.pdf>
3. Selected survey reference materials
4. Pharmacy survey cover letter, confidentiality letter, survey collection tool and instructions